

ACKNOWLEDGEMENT

I have been given the opportunity to review the Columbus Neighborhood Health Center, Inc's ***HIPAA Notice of Privacy Practices***.

I have been given the right to receive a paper copy of the full notice.

If this notice is revised, I understand that the revised copy will be posted at each of the centers within the Columbus Neighborhood Health Center, Inc.

This notice is effective April 14, 2003.

X _____
Signature of Patient or Legal Guardian

X _____
Date

* Please sign and date. *